

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/03/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155275	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/28/2011
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NAME OF PROVIDER OR SUPPLIER WATERS OF PRINCETON, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 1020 WEST VINE STREET PRINCETON, IN 47670
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 000 INITIAL COMMENTS

F 000

This visit was for the recertification and state
licensure survey.

Survey Dates:
January 24, 25, 26, 27, 28, 2011

Facility Number: 000175
Provider Number: 155275
AIM Number: 100274440

Survey Team:
Jodi Meyer, RN,TC
Diane Hancock, RN[1/26-27/11]
Sue Webster, RN
Guylene Maurer, RD [1/24-26/11]

Census Bed Type:
SNF/NF= 59
Total=59

Census Payor Type:
Medicare= 7
Medicaid= 43
Other= 9
Total= 59

Sample: 15
Supplemental sample: 6

This deficiency also reflects state findings in
accordance with 410 IAC 16.2.

Quality review completed 2-2-11
Cathy Emswiller RN

F 282 483.20(k)(3)(ii) SERVICES BY QUALIFIED
SS=D PERSONS/PER CARE PLAN

The services provided or arranged by the facility

Preparation and/or execution of this
plan of correction in general, or this
corrective action in particular, does
not constitute an admission or
agreement by this facility of the facts
alleged or conclusions set forth in this
statement of deficiencies. The plan of
correction and specific corrective
actions are prepared and/or executed
in compliance with state and federal
laws.

**F282 Services by qualified
persons/per care plan:**
It is the intent of this facility to follow
the Physician's written plan of care
and that a medication ordered with a
meal is given with a meal.

1. ACTIONS TAKEN:

In regards to resident # 5:
M.D. notified on 1-26-11 by DON of
medication being given before meal
was served. The RN was counceled
and educated in regards to following
a Doctor's order.

2. OTHERS IDENTIFIED:

A. 100% audit of all MD orders for
medications to be given with
meals/food was completed. No other
residents were identified.

RECEIVED

FEB 14 2011

LONG TERM CARE DIVISION
INDIANA STATE DEPARTMENT OF HEALTH

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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NAME OF PROVIDER OR SUPPLIER

WATERS OF PRINCETON, THE

STREET ADDRESS, CITY, STATE, ZIP CODE
1020 WEST VINE STREET
PRINCETON, IN 47670

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F 282 Continued From page 1
must be provided by qualified persons in
accordance with each resident's written plan of
care.

This REQUIREMENT is not met as evidenced
by:
Based on observation, interview and record
review, the facility failed to ensure the written
physician's plan of care was followed, for 1 of 6
supplemental sample residents observed during
the medication pass, in the supplemental sample
of 6, in that a medication ordered with supper was
given prior to the meal. (Resident #5)

Finding includes:

1. On 1/26/11 at 3:30 p.m., RN #3 was observed
administering medications to Resident #5. The
medications included, but were not limited to,
Tamsulosin [Flomax, used for enlarged prostate]
0.4 milligrams [mg] one tablet, given by mouth
with water.

Resident #5's clinical record was reviewed, at
3:45 p.m. on 1/26/11. The physician's orders,
signed on 1/3/11, indicated the Flomax was to be
given with supper.

RN #3 was interviewed, at 4:15 p.m. and
indicated she usually gave the medications at
around 4:30 p.m.

Resident #5 was observed to receive his supper
tray at 5:05 p.m. on 1/26/11.

3.1-35(g)(2)

F 282

3. MEASURES TAKEN:

- A. In- Serviced all Licensed nurses on 1-
26-11 and 1-27-11 in regards to
following physician orders, and
administering medications with
meals/food as ordered.

4. HOW MONITORED:

- A. D.O.N./designee will perform random
medication administration audits one
time per week on each medication
cart in the facility until 100%
compliance is obtained.
- B. PRN Pharmacy will perform two
random audits per month for three
months.
- C. Adm./Designee will review all audits
as completed in daily QA meeting;
and in quarterly QA meeting with
the Medical Director. The
QAA Committee will
determine if additional
monitoring is required.

5. DATE COMPLETED:

This plan of correction
constitutes our credible
allegation of compliance with
all regulatory requirements.
**Our date of compliance is
February 11th , 2011.**